OVERUTILIZATION OF HEALTH CARE*

WILLIAM R. ROY, M. D.

Director of Medical Education
St. Francis Hospital
Topeka, Kansas

IF we agree that we are unable or unwilling to provide all possible medical care for everyone, the problem is not overutilization of medical care. To put it another way, even if we never again do an unnecessary medical procedure or test, it is possible to continue to increase the costs of medical care at present runaway rates simply by providing services of assumed or proved (although perhaps marginal) benefits.

We as a society—and especially as physicians—are comfortable when we talk about eliminating the overutilization of health services. We have been made aware of redundant tests, unnecessary procedures, and even tests and procedures with a greater potential for harm than good. We recognize and work to eliminate iatrogenic illnesses and nosocomial infections.

We can all agree that we must work continually to evaluate services and to discontinue those that are useless or inordinately dangerous relative to potential benefits. These are surely endeavors that physicians can engage in with enthusiasm. As we observe physician efforts around the country this is being done with increasing diligence and enthusiasm.

But there is no local enthusiasm for telling another physician that a procedure or test should not be done because likely benefits are marginal or too small compared to costs. In fact, the opposite often happens. Every member of a hospital department is likely to adopt a new test or procedure if someone says that the results of this test should be recorded on the chart in case of an allegation of malpractice.

Services cost money and government payers are enthusiastic about stabilizing or slowing the growth of utilization of services. As a result, many private physicians have made good faith efforts to accomplish the same goals.

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Four federal government efforts are worth discussion. You will quickly recognize these as justified efforts, but not as solutions. For this reason, after I discuss these efforts, I shall present an alternative proposal to control the utilization of medical services.

The federal regulations are: Professional Standards Review Organizations (PSRO) and Utilization Review; the Health Planning and Resources Development Act; Title II, A Limitation in Capital Expenditures of Legislation Proposal and presented April 25, 1977; and Title I, A Limitation on Hospital Expenditures, also introduced April 25, 1977.

Each proposal undertakes to decrease the amount the government spends for medical services by limiting the utilization of medical services. Each regulatory effort is more severe and, to most physicians, more onerous than the previous one. But these federal actions make every sane physician realize that, sooner or later, by one mechanism or another, the government will turn down the money faucet, or at least lower the water pressure.

The first instrument that the government provided for this purpose was PSRO and utilization review. While many physicians still are dismayed that the government wants to know whether services paid for by tax dollars are necessary, provided in an appropriate setting, and of reasonable standards, substantial numbers of physicians are trying to make the PSROs work and there are isolated reports of benefits.

However, there is a consensus that the PSROs have failed to control utilization and to contain costs. Paul Sanazaro recently suggested, "If peer review has not had a specific effect on hospital use...we might relieve PSROs of the costly necessity to do concurrent reviews [and] program costs could then be allocated to the basic function of PSROs—namely quality assurance."[1]

About a year ago I wrote: "Patients, physicians, and institutions frequently do not perceive utilization and PSRO activities to be in their own best interest. For example, it is not perceived by the patient to be in his or her best interest to be moved from a site where care is paid for by insurance to a site where care is not paid for by insurance. It is often not perceived by the physician to be in his or her best interest to take the time necessary for such efforts or to try to supersede his judgment for a colleague's judgment. And it is not perceived by a hospital that is half empty and running in the red to be in its best interest to send patients out of the hospital at the earliest possible moment."

I concluded, "Because even government cannot expect individual pa-

tients or institutions to do the things that they believe are not in their best interest, these regulatory efforts have a doubtful future as effective cost containing mechanisms.''[2]

I would add that, procedure by procedure, test by test, case by case, and day-by-day review is tedious, expensive, and subject to a great deal of subjective judgment.

The four major reasons that federal programs or regulatory efforts fail are: the law is a bad law, funding is inadequate, administration is poor, or the regulated defeat of capture of the regulated.

PSRO is, in my opinion, a bad law for cost containment. It may help assure a higher quality of care, although evidence is that this is not so. Parenthetically, the future demise of the PSRO law may also signal the end of any government attempt to permit the medical profession to regulate itself. In this respect, our profession's stake in the PSRO law remains high.

The second federal regulatory effort to limit the utilization of medical services is the Health Planning and Resource Development Act, one in which I have a proprietary interest. The heart of this law is local and state decision making and it is generally agreed that the setting of priorities at the local level is preferable to monolithic federal controls because the former are more responsive to local needs and encourage pluralism. The theory of the law is that people—not just health professionals—should decide before they are implemented what medical services they are willing to pay for and then to approve only the capital expenditures necessary to achieve these services.

This law, like the PSRO law, has a major defect which, unless remedied, may make the law ineffective for its major purpose, the regulation of capital expenditures and subsequent limitation of the capacity of the medical care system. The defect is that local boards are likely to approve expenditures for facilities because services provided are paid for by other than local people. Medicare pays 30 to 40% of most community hospital bills and everyone in the country is taxed to pay for Medicare. Medicaid, federal and state tax supported, may pay 10%, and private insurance premium payers in and out of the area are likely to pay as much as 40% of the hospital's charges. Very little of the cost of operating the community hospital hits the pocket books of local people directly.

This is probably why a 1975 survey of 20 states with bodies empowered to control capital expenditures showed that they approved 93% of projects submitted and 91% of expenditures proposed.

The third federal regulatory effort, at this time only a proposal, would remedy this defect in the new health-planning law by placing a state-by-state limitation on capital expenditures.

The fourth regulatory effort, also a proposal, is the real club to limit the utilization of services. This limits hospital reimbursement by all payers to an annual increase of 9% versus the recent experience of 15% annual increases. This federal proposal is consistent with current state laws which limit Medicaid payments.

I have no real clue whether Congress will enact the recent administration proposals into law. On one hand there is the promise of saving two billion dollars during the next fiscal year while on the other hand there is a real chance that Freymann's[3] suspicion "that the community hospital will join the politically sancrosanct status of the family farm and neighborhood school" may be true; but then look at what government has joined in doing to the family farm and neighborhood school in the name of efficiency and equity.

Regulation by the federal government is deservedly very unpopular. It often does not consider or meet the diverse nature and needs of the many sections of our nation. Regulators are by definition adversaries of those whom they regulate. Adversaries may be a great burden, but they are also subject to capture by the regulated industry to the detriment of the general public. Recent federal regulatory programs have been underfunded and poorly administered or both. Regulation by itself always costs money.

The only alternative to allocation by regulation is allocation by the market system. Where certain marketplace characteristics exist, American industry is less regulated, and less regulated industries are generally judged to be more efficient, more effective, and more responsive to public needs than heavily regulated industries.

Is it too much to hope that the medical-care industry can be competitive (and thereby subject to less regulation) and that society can maintain a high degree of equity of access to quality medical services? A corollary to this question is whether we can establish universal health insurance without not only completely regulating the system, but making the system inflexible to future change and closed to innovation.

I have never been able to believe that a conscientious physician can oppose everyone having financial access to medical care—unless he assumes that this means regulation, regimentation, and loss of income. If we physicians, who are generally politically conservative, do really believe in the free enterprise system, the market place, competition, and the laws of

supply and demand, then the restoration of a medical-care marketplace should be our goal and it should be much more easily done than were physicians opposed to these principles.

Two components would be necessary to establish a medical-care market on a one-on-one basis and at the same time not deny individuals medical care because of cost. The first would outlaw all health insurance except catastrophic health insurance, and the second would make certain that everyone has a guaranteed annual income. This degree of consumer access to the market, combined with better provider access to the market (e.g., less credentialling), would permit people to buy or not buy medical services depending upon the value that each person places on the given service. But this will not happen for a variety of reasons.

An alternative is for groups of prudent purchasers to bargain with groups of private medical providers. There would still be some government regulation. To prevent recurrence of the prepaid health plans' scandals of former Governor Ronald Reagan's California administration, organized provider groups would have to meet certain standards of accountability such as quality standards, capacity, and the provision of catastrophic medical services. But then do not nearly all industries, American or otherwise, have to meet similar standards of accountability?

In addition, as is the theory with all American industry, monoply would not be permitted. The purchaser of medical services would have a choice of two or more competing organized provider groups or public utilitylike regulation would be necessary. In most respects, competing private medical-provider groups would not have the characteristics of public utilities and public utility regulation would be neither necessary nor appropriate. Paradoxically, perhaps the best that our present medical-care system, which has few competitive features, can hope for is to be regulated like a public utility.

It would be expected that organized medical-provider groups could change their internal organizational structure quickly and easily to respond to the purposes and desires of the groups of prudent purchasers and could fully utilize for their patients' benefits the state of the art and science of medicine as it exists at a given time.

Providers could organize as HMOs, independent practice associations, Ellwood's[4] more recently proposed health-care alliances, or Freymann's "mission-oriented hospitals," the American Hospital Association's health-care corporations (not franchised), or in any of a multitude of ways not presently conceived.

Some believe that a voucher worth a given number of dollars, either purchased by the individual, by an employee-employer plan, or by government for the poor—or universally purchased by government—would expedite and perhaps guarantee medical-care system changes which would assure greater competition and lessen the need for federal or state government regulation.

It is my present judgment (subject to change without notice) that the utilization of medical services can be best controlled and rationalized by consumer and provider incentives for efficiency of effectiveness rather than by the confrontation and adversary proceedings of government regulation.

A long list of benefits emanating from competition among private medical organizations could be expected. Some are:

1) Probable savings from discontinuing the present practice of reimbursing on a fee-by-procedure basis. This is consistent with Dr. Jack Meyers' statement in the June 1976 *Bulletin of the American College of Physicians*. He wrote, "One of the major factors, in my opinion, in determining increased costs is the practice... of paying charges by procedure. This encourages the utilization of procedures...the practice of paying by procedure should be changed."

2) Better services for presently underserved areas. It is safe to predict that organizations would compete to meet the needs of inner city and rural people who possess the ability to pay.

3) Private medical organizations are unlikely to support a surplus of physicians of any one specialty, or to purchase specialist services more economically. The well-compensated 20-hour-a-week surgeon could disappear and residency choice would be made on the basis of demand for the specialty. Medical schools would change without legislative tinkering with their admission policies and curricula.

4) Duplication of services would not be economical. Underutilized services would be limited or closed and purchased elsewhere, e.g., employment of 50% of the services of a plastic surgeon would be likely.

5) Only proved new technology, tests, and procedures would be adopted. There would be new definitions of obsolescence, but competition would require accurate, reliable, efficient technology.

6) The physician could remain the advocate for his individual patient consistent with the physician's ethic from Hippocrates to today.

7) The market would determine the total use of medical services, consistent with the will of the people expressed through an effective economic system rather than having total use determined by a governmen-

tal determination of the total resources to be allocated for medical services.

8) Quality would be in part assured because services of poor quality would be costly for the providers. For example, today an in-hospital infection is at best inconvenient and at worst fatal to the patient, but the same infection is a source of more revenue for the hospital and patient.

The list of good probabilities could go on. A list of bad probabilities also can be made, but I shall leave that to another time and another place.

In closing, let me reiterate that I can conceive of the market regulating the utilization of medical services better than I can conceive of government regulating the utilization of medical services.

NOTES AND REFERENCES

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2. Roy W. R.: Shattuck lecture—An agenda for physicians and legislators. *N. Engl. J. Med. 295*:589-96, 1976.
3. Freymann, J. G.: Organization of the health care system: Logical fantasy versus illogical reality. *Bicentennial Conf. on Health Policy Agendas, 1976-1986*. Philadelphia, University of Pennsylvania, November 11-12, 1976.
4. The Ellwood reference is about P. M. Ellwood and Health Care Alliances—an article which appeared in *Medical Economics* on March 21, 1977, pp. 23-42, entitled "A New Scheme to Force You to Compete for Patients," by James K. Reynolds.